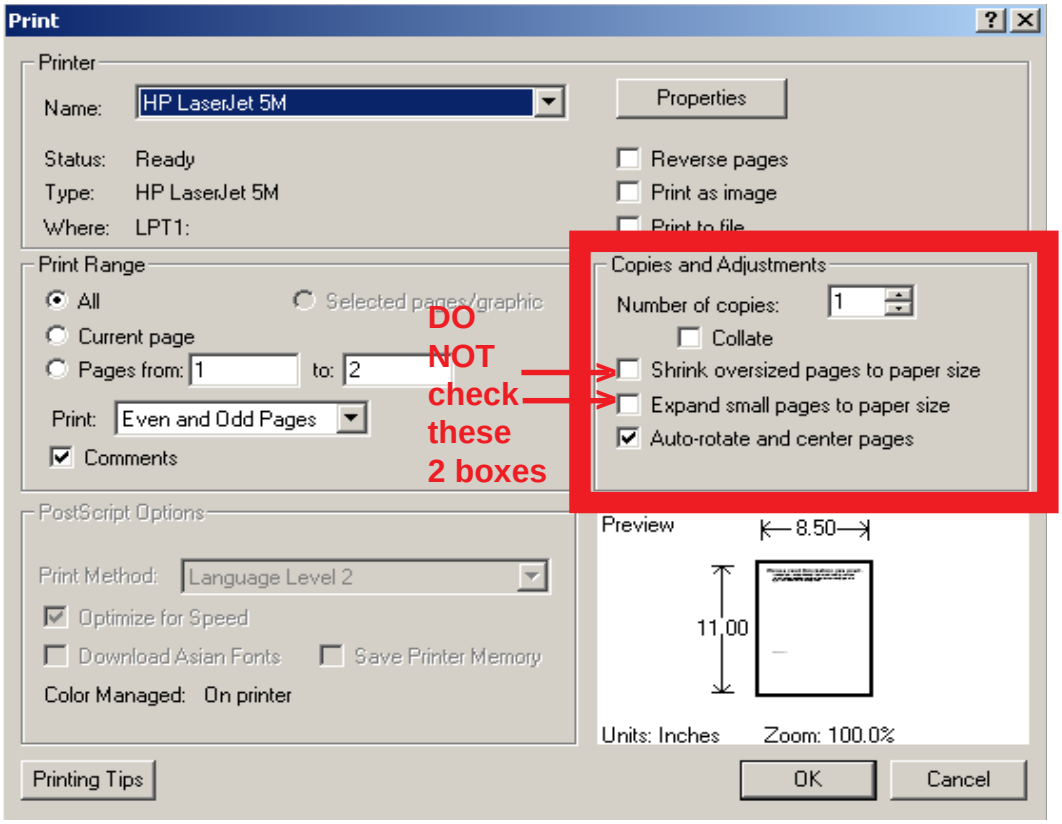
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



(This page intentionally left blank.)

Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents: Marriage and Family Therapist License Application Packet

1. 670-042 .... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 670-004 .... Application Instructions for Licensed Marriage and Family Therapist ..... 2 pages
3. 670-003 .... Application for Marriage and Family Therapist ..... 4 pages
4. 670-007 .... Out of State Verification of Reg/Cert/Lic as a Marriage and Family Therapist ..... 1 page
5. 670-005 .... Verification of Marriage and Family Therapy Supervision and Experience ..... 2 pages

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Marriage and Family Therapist

DEPOSIT SLIP

DOH 670-042 (REV 8/2003)

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

1F 0207050000 00451

(This page intentionally left blank.)

Washington State Department of Health

Application Instructions For Licensed Marriage and Family Therapist

Application Fee **$50.00** Initial Licensure Fee **$25.00** **ALL FEES ARE NON-REFUNDABLE** Send the application and fee to: Department of Health Counselor Programs PO Box 1099 Olympia, WA 98504-1099	If you are sending **supporting documents** separate from the four-page application form, please mail to the following address: Department of Health Counselor Programs PO Box 47869 Olympia, WA 98504-7869

1. Demographic Information

Please complete the application form. To assure appropriate review, all information should be typed or printed clearly. A resume will ***not*** substitute for completion of the application. It is the applicant's responsibility to keep the Department of Health, Counselor Programs, informed of any address change.

2. Previous Certification/Licensure/Registration

List all states in which you now hold or have held a certification, license, or registration to practice as a Marriage and Family Therapist or any other professional certification, license, or registration. Also, include those states in which you may have applied and a certification, license, or registration was not granted. Please include an explanation. This form may be duplicated. **Please send the out-of-state Verification form to each state in which you held a Marriage and Family Therapist certification, license, or registration, even if it has now expired.**

3. COAMFTE Accredited Program

If you have completed a master's program accredited by the Commission on Accreditation for Marriage and Family Therapy Education **(COAMFTE)** of the American Association for Marriage and Family Therapy, you may be credited with five hundred **(500)** hours of direct patient contact and one hundred **(100)** hours of formal meetings with an approved supervisor. If you are not sure whether your university was **COAMFTE** approved, please contact your university for clarification.

Note: regarding the "Method of Licensure", EXAM = examination, END = endorsement, and GP = grandparenting.

4. Personal Data Questions

If any questions on the Personal Data page have a **"Yes"** response, **the supporting documents and explanation required for that answer must be attached.**

5. Education

Request an official copy of your master's degree transcripts from the graduate school granting the degree. **Transcripts must be mailed directly to the department from your school.**

6. Educational Qualifications

If your graduate school is ***not*** accredited by the Commission on Accreditation of Marriage and Family Therapy Education **(COAMFTE)**, you are required to complete this section.

7. Aids Education And Training Attestation

Please read carefully the AIDS education and training attestation. After you have completed a minimum of four (4) hours of AIDS education, initial and date the attestation.

8. Applicant's Attestation

After you have familiarized yourself with the statutes cited in your counselor law book, sign and date the attestation.

Experience Requirement

Minimum of **two calendar years** of full-time marriage and family therapy. Of the total supervision, one hundred **(100)** hours must be with a licensed marriage and family therapist with at least five years clinical experience; the other one hundred **(100)** hours may be with an equally qualified licensed mental health practitioner. Total experience requirements include:

A minimum of three thousand **(3000)** hours of experience, one thousand **(1000)** hours of which must be direct client contact; at least five hundred **(500)** hours must be gained in diagnosing and treating couples and families; plus

At least two hundred **(200)** hours of qualified supervision with a supervisor. At least one hundred of the two hundred hours must be one-on-one supervision, and the remaining hours may be in one-on-one or group supervision.

Out-Of-State Verification Form

This form is required if you hold or have held a certification, license, or registration to practice as a Marriage and Family Therapist or any other professional certification, license, or registration.

Examination Information

- Once you have been approved to take the examination, you will be sent an approval letter. This letter gives you further information on how to register for the examination. **A national exam (AMFTRB) is required if you have not previously taken and passed it.**
- The Department receives score reports within 6 to 8 weeks of administration from the testing company. You will be notified by mail of the examination score. Scores **will not** be given over the phone. Once you have completed all the requirements and have passed the **AMFTRB** examination and the $25 initial licensure fee has been received, licensure will be granted.

OR

- If an examination is not required and all other requirements have been met, including the $25 initial licensure fee, licensure will be granted.

National Examination Dates and Cutoff Dates:

Exam Date	Cutoff Date for Application, Fee and Supporting Documents
September 15, 2003 thru October 11, 2003	June 3, 2003
January 19, 2004 thru February 14, 2004	October 15, 2003
May 17, 2004 thru June 12, 2004	February 7, 2004
September 13, 2004 thru October 9, 2004	June 1, 2004

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE NO:	LICENSE DATE:
APPROVED BY:	
VALIDATION INFORMATION:	

LICENSE #

Application for Marriage and Family Therapist

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

MAILING ADDRESS

CITY | STATE | ZIP | COUNTY

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

Note: Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

GENDER ☐ Female ☐ Male | BIRTHDATE | PLACE OF BIRTH

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, other name(s):

2. Previous Certification/Licensure/Registration

List **all** states (including Washington) where certifications/licenses/registrations are or were held. Specifically list certifications/licenses/registrations granted by examination, endorsement, or grandparenting.

STATE	CERTIFICATION/LICENSE TYPE	License/Registration/Certification		METHOD OF LICENSURE		
		YEAR ISSUED	NUMBER	EXAM	END	GP

An "Out of State Verification for Registration/Certification/Licensure" form is enclosed and must be sent to each state listed above. Enter your full name and birthdate at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

3. COAMFT Accredited Program

Applicants who have completed a master's program accredited by the commission on accreditation for marriage and family education of the American Association for Marriage and Family Therapy may be credited with five hundred hours of direct client contact and one hundred hours of formal meetings with an approved supervisor.

Was your master's program accredited? ☐ Yes ☐ No

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Education

Please provide a chronological listing of graduate school(s) attended, major, and month and year the degree was granted. A transcript is to be requested from the graduate school(s) and sent **directly** from the graduate school to the Department of Health, Mental Health Licensure Section per instructions.

GRADUATE SCHOOL	DEGREE AND MAJOR	DEGREE GRANTED	
		MONTH	YEAR

6. Educational Qualifications

Applicants for Marriage and Family Therapist Licensure must have at least a masters degree in marriage and family therapy or equivalent course work. Please fill in the outline to aid in our review if you did not complete a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education. If any course listed does not specify clearly in its title the nature and/or content, please provide an official syllabus, official course outline, or statement from the professor documenting the content.

The equivalent course of graduate study shall include courses in marital and family therapy, individual development, psychopathology, human sexuality, research, professional ethics and law, supervised clinical practice and electives. A total of forty-five semester credits or sixty quarter credits are required. A minimum of twenty-seven semester credits or thirty six quarter credits are required in the first five areas of study: Marital and Family Systems, Marital and Family Therapy, Individual Development, Psychopathology, Human Sexuality and Research.

1. Marital and Family Systems (2 courses) minimum 6 semester credits or 8 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

2. Marital and Family Therapy (2 courses) minimum 6 semester credits or 8 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

3. Individual Development (1 course) minimum 2 semester credits or 3 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

4. Psychopathology (1 course) minimum 2 semester credits or 3 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

5. Human Sexuality (1 course) minimum 2 semester credits or 3 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

6. Research (1 course) minimum 3 semester credits or 4 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

7. Professional Ethics and Law (1 course) minimum 3 semester credits or 4 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

6. Educational Qualifications (Continued)

8. Supervised Clinical Practice 9 semester credits or 12 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

9. Electives (1 course) minimum 3 semester credits or 4 quarter credits

COURSE TITLE	NUMBER	SEMESTER CREDITS	QUARTER CREDITS

7. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

Signature of Applicant_____ Date _____

Official Use Only

Washington State Records Center

Washington State Department of Health

Out of State Verification of Registration / Certification / Licensure as a Marriage and Family Therapist

Applicant Name: _____ Birthdate: _____

I, _____ ,Secretary of _____ ,
OFFICIAL NAME OF BOARD

hereby certify that _____

was granted state: ☐ Registration ☐ Certificate ☐ License

Number: _____ to practice _____

in the State of _____ on the _____ day of _____ , 20 _____.

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

On the basis of:

☐ Successfully passing the Association of Marriage and Family Therapy Regulatory Board's (AMFTRB) Examination in Marital and Family Therapy

☐ Yes ☐ No **1,000 hours** Postgraduate Direct Client Marriage and Family Therapy

☐ Yes ☐ No **200 hours** Postgraduate Formal Supervision. **100 hours** must be one-on-one supervision.

☐ Yes ☐ No **500 hours** in diagnosing and treating couples and families.

☐ Yes ☐ No **3,000 hours** of experience in a minimum of **24 months** full-time marriage and family therapy.

Status of License: ☐ Current Expiration Date: _____

☐ Expired Date _____

S
E
A
L

Acting In Behalf of the:

_____ _____
OFFICIAL NAME OF BOARD PHONE

_____
SECRETARY

_____
DATE CERTIFICATION PREPARED

Return to: **Department of Health**
Counselor Programs
PO Box 47869
Olympia, WA 98504-7869

(This page intentionally left blank.)

Washington State Department of Health

Verification of Marriage and Family Therapy Supervision and Experience

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill out Section 1 and forward the verification form to the supervisor for completion.

1. Print or Type Clearly:

NAME LAST	FIRST	MIDDLE	BIRTH DATE
ADDRESS			
CITY	STATE		ZIP

2. Approved Supervisor:

The above individual seeks verification of supervised marriage and family therapy experience for licensure as a Marriage and Family Therapist. Please complete the following:

SUPERVISOR NAME	CURRENT PHONE
CURRENT STREET ADDRESS	
CITY	STATE	ZIP

Supervised Postgraduate Experience:

A minimum of **three thousand (3,000) hours** of experience is required in a minimum of two calendar years of full-time marriage and family therapy.

Dates applicant was supervised from: _____ to: _____

Supervision	Total Hours
Total number of **hours** applicant provided direct client marriage and family therapy services. **(1,000 hours required)**	
Total number of **hours** applicant gained in diagnosing and treating couples and families. **(500 hours required)**	
Total number of **hours** of qualified supervision with a supervisor (includes one-on-one or group supervision). **(200 hours required)**	
Of the 200 hours of formal meetings, at least **one hundred** must be in one-on-one supervision. **(100 hours required)**	
Total Number of Supervised Experience Hours	

Washington State Department of Health

Marriage and Family Therapy
Statement of Qualifications

Note to Supervisor:

The experience requirement consists of a minimum of two calendar years of full-time marriage and family therapy. Of the total supervision, one hundred hours must be with a licensed marriage and family therapist with at least five years clinical experience; the other one hundred hours may be with an equally qualified licensed mental health practitioner.

Do not sign this form verifying applicant's hours unless you meet the criteria and can provide documentation if requested to do so.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signature _____

Title _____

Print Full Name _____ Date _____

Street Address _____

City _____ State _____ Zip _____

Daytime Phone ( ) _____

Please return this form directly to:

Department of Health
Counselor Programs
P.O. Box 47869
Olympia, WA 98504-7869